VIRGINIA HOME AND COMMUNITY BASED WAIVER
CHOICE OF PROVIDERS **

Individual:_____ **Medicaid #:**_____

I have reviewed information about and/or visited the sites of the providers available under the

☐ Mental Retardation Waiver

☐ Day Support Waiver

as listed on the Provider Roster provided by DMHMRSAS, in the location(s) of my choice. I have freely chosen services based upon my needs and interests. I am aware of the fact that I may contact my case manager at any point in the future to discuss concerns that I cannot resolve, with the option of changing Waiver providers. I have selected the following provider(s):

PROVIDER NAME	**TYPE OF WAIVER SERVICE**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

****Choice must be documented at the initiation or start-up of any Waiver services, whenever requested thereafter, if the case manager has reason to believe that the individual may benefit from offering choice of providers, or when an individual/authorized representative is dissatisfied with current services.**

_____ _____

Individual/Legal Guardian Signature & Date Case Manager Signature & Date

_____

Authorized Representative Signature & Date

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